

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G252 11-30-59 et

CERTIFICATE OF DEATH

12647

Reg. Dist. No.

12668

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall			
				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Clothier				4. DATE OF DEATH Month Day Year November 18 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1892	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Clothier (First name unknown)				14. MOTHER'S MAIDEN NAME Emma Dephen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 818-16-9746			
17. INFORMANT Mrs. Ruth Clothier--Rock Hall, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tubercular Edema 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO (c) Chronic Obstructive Pulmonary Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 6, 1959 , to Nov 18, 1959 , that I last saw the deceased alive on Oct 5, 1959 , and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norbert C Nitsch M.D.				ADDRESS (Street, city or town, state) Rock Hall			
DATE SIGNED							
PHYSICIAN'S NAME (Type) NORBERT C NITSCH				ROCK HALL MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 21		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane				ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR DATE NOV 24 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kane			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12648

12669

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>WORTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WORTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES LEE CRANFILL JR</u>		4. DATE OF DEATH <u>NOV 3 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 14 1944</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES LEE CRANFILL</u>		14. MOTHER'S MAIDEN NAME <u>MEDRA MIDGETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS C. L. CRANFILL</u>		Address <u>WORTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN INJURY</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>NONE</u>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HIT BY CAR</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 3 1959</u> Hour <u>7</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) <u>WORTON</u> (County) <u>KENT</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Arthur J. Keefe</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A T KEEFE, JR. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-6-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CHESTER CEMETERY</u>		22d. LOCATION (City, town, or county) <u>CHESTERTOWN, MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD</u>		24a. REC'D BY REGISTRAR <u>NOV 5 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Keefe</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

DATE OF DEATH
2-2-1917

LAST
RESIDENCE
BOSTON

AGE
60

SEX
M

RACE
W

RELIGION
C

EDUCATION
H

PROFESSION
C

DATE OF BIRTH
2-2-1857

PLACE OF BIRTH
MASS

DATE OF DEATH
2-2-1917

PLACE OF DEATH
MASS

CAUSE OF DEATH
C

MANNER OF DEATH
C

DEATH CERTIFICATE
C

DEATH RECORD
C

DEATH CERTIFICATE
C

DEATH RECORD
C

DEATH CERTIFICATE
C

DEATH RECORD
C

12670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Skinner's</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Goldy</u> Last <u>Elburn</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>19-59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 6 1911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Elburn</u>				14. MOTHER'S MAIDEN NAME <u>Alice Brady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-0019</u>		17. INFORMANT Address <u>Mrs. Clara Elburn Rock Hall P.O. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 10, 1959</u> , to <u>November 15, 1959</u> , that I last saw the deceased alive on <u>November 14, 1959</u> , and that death occurred at <u>3:20</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A.C. Dick</u>				ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>11-15-59</u>			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 17, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Am. T.</u>		22d. LOCATION (City, town, or county) <u>Rock Hall Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin Williams</u> ADDRESS <u>Chestertown, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
				DATE <u>NOV 18 1959</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

18650

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE	
15. SIGNATURE OF SHERIFF		16. SIGNATURE OF CORONER	
17. SIGNATURE OF JURY		18. SIGNATURE OF COURT	
19. SIGNATURE OF COUNTY		20. SIGNATURE OF STATE	
21. SIGNATURE OF DEPARTMENT		22. SIGNATURE OF NATION	
23. SIGNATURE OF PEOPLE		24. SIGNATURE OF WORLD	
25. SIGNATURE OF UNIVERSE		26. SIGNATURE OF GOD	
27. SIGNATURE OF HEAVEN		28. SIGNATURE OF EARTH	
29. SIGNATURE OF FIRE		30. SIGNATURE OF WATER	
31. SIGNATURE OF AIR		32. SIGNATURE OF SPIRIT	
33. SIGNATURE OF SOUL		34. SIGNATURE OF BODY	
35. SIGNATURE OF MIND		36. SIGNATURE OF HEART	
37. SIGNATURE OF LUNGS		38. SIGNATURE OF LIVER	
39. SIGNATURE OF STOMACH		40. SIGNATURE OF SPLEEN	
41. SIGNATURE OF PANCREAS		42. SIGNATURE OF GALLBLADDER	
43. SIGNATURE OF SMALL INTESTINE		44. SIGNATURE OF LARGE INTESTINE	
45. SIGNATURE OF RECTUM		46. SIGNATURE OF UTERUS	
47. SIGNATURE OF VAGINA		48. SIGNATURE OF PENIS	
49. SIGNATURE OF TESTES		50. SIGNATURE OF OVARY	
51. SIGNATURE OF FALLOPIAN TUBE		52. SIGNATURE OF UTERINE CERVIX	
53. SIGNATURE OF VAGINAL CERVIX		54. SIGNATURE OF VAGINAL CANAL	
55. SIGNATURE OF VAGINAL OPENING		56. SIGNATURE OF VAGINAL CLOSURE	
57. SIGNATURE OF VAGINAL MUCOSA		58. SIGNATURE OF VAGINAL EPITHELIUM	
59. SIGNATURE OF VAGINAL GLANDS		60. SIGNATURE OF VAGINAL MUSCLES	
61. SIGNATURE OF VAGINAL NERVES		62. SIGNATURE OF VAGINAL BLOOD VESSELS	
63. SIGNATURE OF VAGINAL LYMPH VESSELS		64. SIGNATURE OF VAGINAL CONNECTIVE TISSUE	
65. SIGNATURE OF VAGINAL SKIN		66. SIGNATURE OF VAGINAL FASCIA	
67. SIGNATURE OF VAGINAL PERITONEUM		68. SIGNATURE OF VAGINAL PERICARION	
69. SIGNATURE OF VAGINAL PERIOVARUM		70. SIGNATURE OF VAGINAL PERIMETRIUM	
71. SIGNATURE OF VAGINAL PERIURETHRUM		72. SIGNATURE OF VAGINAL PERIVAGINITIS	
73. SIGNATURE OF VAGINAL PERIVAGINITIS		74. SIGNATURE OF VAGINAL PERIVAGINITIS	
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99. SIGNATURE OF VAGINAL PERIVAGINITIS		100. SIGNATURE OF VAGINAL PERIVAGINITIS	

1. NAME OF DECEASED
2. PLACE OF BIRTH
3. SEX
4. AGE
5. OCCUPATION
6. CAUSE OF DEATH
7. DATE OF DEATH
8. TIME OF DEATH
9. PLACE OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF WITNESSES
12. SIGNATURE OF REGISTRAR
13. SIGNATURE OF CLERK
14. SIGNATURE OF JUDGE
15. SIGNATURE OF SHERIFF
16. SIGNATURE OF CORONER
17. SIGNATURE OF JURY
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99. SIGNATURE OF VAGINAL PERIVAGINITIS
100. SIGNATURE OF VAGINAL PERIVAGINITIS

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

12661

12650

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Betherton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne's Hospital</u>		1. d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Celena</u> Last <u>Eley</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>85</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Berne Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Rawley</u>		14. MOTHER'S MAIDEN NAME <u>Susan Abnet</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, generalized.</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma (original site unknown)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 9, 1959</u> , to <u>November 28, 1959</u> , that I last saw the deceased alive on <u>November 28, 1959</u> , and that death occurred at <u>6:00</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.C. Dick</u>		ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>11-28-59</u>	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		CHESTERTOWN, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows</u>	22d. LOCATION (City, town, or county) (State) <u>Ameyra Del</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Talbot</u>		24. REC'D BY REGISTRAR <u>Christie S. Thomas</u>	
ADDRESS		DATE DEC 2 '59	

12671

CERTIFICATE OF DEATH

12651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RFD (Coleman's)		c. LENGTH OF STAY IN life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Worton - RFD (Coleman's)	
		f. STREET ADDRESS RFD	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle J. Last Frisby		4. DATE OF DEATH Month Nov. Day 26 , Year 1959	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1869
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Brown		14. MOTHER'S MAIDEN NAME Jane Kennard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Marie Gibbs daughter		Address Worton R.F.D. Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary edema 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right sided heart failure DUE TO (c) Cardiac hypertrophy			INTERVAL BETWEEN ONSET AND DEATH 2 hours 2 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio renal disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1 , 19 59 to Nov. 26 , 19 59 , that I last saw the deceased alive on Nov. 26 , 19 59 , and that death occurred at 6 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Florence Deringer Joyce M.D.		ADDRESS (Street, city or town, state) Worton, Md RFD DATE SIGNED 11/27/59	
PHYSICIAN'S NAME (Type) Florence Deringer Joyce			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 6, 1959	22c. NAME OF CEMETERY OR CREMATORY Coleman's Cem.	22d. LOCATION (City, town, or county) (State) Worton, Md/ R. F.D;
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker		24a. REC'D BY REGISTRAR DATE DEC 1 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12662
CERTIFICATE OF DEATH

Reg. Dist. No.

12652

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QA HOSPITAL		d. STREET ADDRESS 430 CALVERT ST	
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Johnson		4. DATE OF DEATH Month Day Year Nov 18 1959	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/1912
9. AGE (In years last birthday) yrs. 47		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JAMES JOHNSON		14. MOTHER'S MAIDEN NAME TEMPLE GRAVES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 220-01-8430	
17. INFORMANT HOSPITAL RECORDS.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OPERATIVE SHOCK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIOVASCULAR COLLAPSE DUE TO (c) Under Anesthesia		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PENETRATING DUODENAL ULCER		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 6 , 19 59 to NOV 18 , 19 59 , that I last saw the deceased alive on NOV 18 , 19 59 , and that death occurred at 2 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESTERTOWN, Md DATE SIGNED 11-19-59			
ACTUAL SIGNATURE A. T. KEEFE, MD		M.D. CHESTERTOWN, Md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1959	
22c. NAME OF CEMETERY OR CREMATORY Janes Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. W. W.		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE NOV 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12653

Reg. Dist. No.

12672

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seaside</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Morgan Kendall</u>				4. DATE OF DEATH Month Day Year <u>Nov. 28 1959</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1905</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Foods</u>		11. BIRTHPLACE (State or foreign country) <u>Rock Hall, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Columbus Kendall</u>				14. MOTHER'S MAIDEN NAME <u>Lena Scorne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>154-09-9647</u>		17. INFORMANT Address <u>Mrs. Joseph Hynson - Rock Hall, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart; angina Pectoris</u> <u>420.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>✓</u> DUE TO (c) <u>✓</u>							INTERVAL BETWEEN ONSET AND DEATH <u>✓</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient dead on my arrival.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>		20f. (City or town) (County) (State) <u>✓</u>
21. I certify that I attended the deceased from <u>11/28</u> , 19 <u>59</u> , to <u>11/28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>✓</u> , 19 <u>59</u> , and that death occurred at <u>9 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Kester</u>				DATE SIGNED <u>Rock Hall</u>			
PHYSICIAN'S NAME (Type) <u>E. Kester</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Dec. 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Ans.</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin V. Wilham - Chestnut Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. P. H.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

12655

12663

1. PLACE OF DEATH o. COUNTY <i>Kent</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chestertown</i>				c. LENGTH OF STAY IN 1b <i>45 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>104 Water St.</i>				d. STREET ADDRESS <i>104 Water St.</i>			
3. NAME OF DECEASED (Type or print) <i>Helin Cooper Metcalfe</i>				4. DATE OF DEATH <i>Nov. 28 1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 12, 1891</i>	9. AGE (In years lost birthday) <i>68 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George S. Cooper</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Stier</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Joseph Brown Metcalfe - Chestertown Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Hypertension</i> DUE TO (c) <i>Atherosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>45 minutes</i> <i>25 years</i> <i>25 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1953</i> to <i>November 28, 1959</i> , that I last saw the deceased alive on <i>Nov. 27</i> , 1959, and that death occurred at <i>9:05 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A.C. Dick</i> M.D.				ADDRESS (Street, city or town, state) <i>Chestertown, Md.</i>			
PHYSICIAN'S NAME (Type) <i>A.C. Dick</i>				DATE SIGNED <i>11-30-59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 30/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Chestertown</i>		22d. LOCATION (City/town, or county) (State) <i>Chestertown Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marvin V. Williams - Chestertown Md.</i>				ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
24a. REC'D BY REGISTRAR <i>DEC 3 '59</i>				DATE			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12664

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> <u>Chestertown</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown R. D. 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent - Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>J.</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1889</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James A. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bruff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Informant</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>1 week</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4) Arteriosclerosis genl. &</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 5</u> , 1959, to <u>Nov. 8</u> , 1959, that I last saw the deceased alive on <u>Nov. 7</u> , 1959, and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Smith Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>117 Water St., Centerville Md.</u>	
PHYSICIAN'S NAME (Type) <u>John R. Smith Jr.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Fairlee Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Sam C. Luck Hill Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 10 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2035

12665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chester town</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sudersville 17x-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kent & Queen Annas Hop.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy</i> First Middle Last <i>Unruh</i>		4. DATE OF DEATH <i>November 11</i> 19 <i>59</i> Month Day Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/11/59</i>
9. AGE (In years lost birthday) <i>4</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hrs. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Samuel Unruh</i>		14. MOTHER'S MAIDEN NAME <i>Charlotte Fisher</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anencephaly</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>11-11-59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-11-59</i> , 19 <i>59</i> , to <i>11-11-59</i> , that I last saw the deceased alive on <i>11-11-59</i> , 19 <i>59</i> , and that death occurred at <i>6 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>O. S. Gulbrandson</i>		ADDRESS (Street, city or town, state) <i>CHESTERTOWN, MD.</i>	
PHYSICIAN'S NAME (Type) <i>O. S. GULBRANDSEN, M.D.</i>		DATE SIGNED <i>11-12-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chester Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Chestertown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Willis Wells</i>		24a. REC'D BY REGISTRAR <i>Nov 13 1959</i>	
ADDRESS <i>Chestertown, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>William E. Kline</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2072254XV4

CERTIFICATE OF DEATH

1922

NOT VALID

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15 1877*

5. Place of birth: *St. Louis, Mo.*

6. Date of death: *Dec 10 1922*

7. Place of death: *St. Louis, Mo.*

8. Cause of death: *Heart Disease*

9. Signature of physician: *J. H. Smith*

10. Signature of registrar: *W. B. Jones*

11. Date of registration: *Dec 15 1922*

12. Place of registration: *St. Louis, Mo.*

12666

CERTIFICATE OF DEATH

12658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN life 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Water St.		d. STREET ADDRESS Water St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Geraldine First W. Middle Whitworth Last		4. DATE OF DEATH Nov. 30, 1959 Month Nov. Day 30 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	11. IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Reg. Nurse		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. B. Wilmer		14. MOTHER'S MAIDEN NAME Ada Leonora Jessop	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary infarct 420.1 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertension (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 30 min. 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1943 to November 30, 1959 that I last saw the deceased alive on November 13, 1959 , and that death occurred at 4:05 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE A. C. Dick		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 12/1/59	
PHYSICIAN'S NAME (Type) A. C. Dick			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/2/59	22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	22d. LOCATION (City, town, or county) (State) nr. Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DEC 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

RECEIVED
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NEW YORK

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE
MANNER OF DEATH
SIGNATURE OF DECEASED
SIGNATURE OF WITNESSES
SIGNATURE OF CLERK
OFFICE OF THE CLERK OF THE SUPREME COURT
ALBANY, N. Y.

CERTIFICATE OF DEATH

Reg. Dist. No.

12659

12667

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 46 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Annes		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Jewell Last Yingling		4. DATE OF DEATH Month Nov Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-1887
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Jewell		14. MOTHER'S MAIDEN NAME Sally Jervis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sallie J. Parsons		Address Worton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, (generalized metastasis) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Breast carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-8- 19 59 , to 11-24- 19 59 , that I last saw the deceased alive on 11-23- 19 59 , and that death occurred at 6:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 203 N. Queen Street DATE SIGNED 11-24-59			
ACTUAL SIGNATURE Harry Paul Ross		M.D. 203 N. Queen Street 11-24-59	
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS, M.D.		Chestertown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 27, 1959	
22c. NAME OF CEMETERY OR CREMATORY Chestertown Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF ORIGIN

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